1. a. **Federally Qualified Health Center and Rural Health Clinic Services**

All Federally Qualified Health Centers and Rural Health Clinics (hereinafter collectively referred to as "clinic/center") shall be reimbursed on a prospective payment system ("PPS") beginning October 1, 2012,

RATE DETERMINATION PROCESS

1. INITIAL RATES
   a. For facilities with an effective date prior to Fiscal Year ("FY") 1999, payment rates will be set prospectively using the total clinic/centers reasonable cost of furnishing core and other ambulatory services for FYs 1999 and 2000, adjusted for any change in scope, divided by the number of encounters for the two year period to arrive at a cost per visit. For each calendar year thereafter, each clinic/center will be paid the per visit amount paid in the previous year, adjusted by the Medicare Economic Index ("MEI") as reported on January 1 and adjusted to take into account any increase (or decrease) in the scope of services furnished during the FY.

   b. For facilities with an effective date on or after FY 2000, payment rates will be set prospectively using the total clinic/centers reasonable cost of furnishing core and covered non-core services divided by the number of encounter for the first full fiscal year of operations. The first full year of operations is defined as a final settled Medicare cost report, as adjusted for Medicaid services, that reflects twelve months of continuous service.

      1. The calculation of the initial PPS rates and any subsequent adjustment to such rate shall be determined on the basis of reasonable costs of the center/clinic as provided under 42 CFR Part 413. Administrative costs will be limited to 30 percent of total costs in determining reasonable costs. Reasonable costs do not include unallowable costs.

      2. Unallowable costs are expenses incurred by a clinic/center that are not directly or indirectly related to the provision of covered services, according to applicable laws, rules and standards.

2. NEW FACILITIES
   A "new" clinic/center is a facility that meets all applicable licensing or enrollment requirements on or after October 1, 2012. Sites of an existing clinic/center that are newly recognized by HRSA are treated, for purposes of this State Plan, as a change in scope of services.

a. A new clinic/center must file a projected cost report to establish an interim initial base rate. The cost report must contain the clinic/center's reasonable costs anticipated to be incurred in the initial FY. The initial rate will be set at the lesser of eighty-percent (80%) of the pro forma allowable cost(s) as established by the interim cost report or the statewide average PPS rate of all existing providers within the same peer group, excluding the lowest and highest rate obtained from the current period.

b. A peer group is divided into three rate groupings; (1) FQHCs; (2) free-standing RHCs and (3) hospital based RHC facilities

c. Each new clinic/center must submit an as-filed Medicare cost report after the end of the clinic/center's FY. An updated interim rate will be determined based on one hundred-percent (100%) of reasonable costs as adjusted for Medicaid services contained in the as-filed cost report. Interim rates will be adjusted prospectively until the final settled Medicare cost report is processed.

d. Each new clinic/center must submit a final settled Medicare cost report, reflecting twelve months of continuous service. The rate established shall become the final base rate for the center/clinic. The State will reconcile payments back to the beginning of the interim period applying the final base rate. If the final base rate is greater than the interim rate, the Bureau for Medical Services ("BMS") will compute and pay the clinic/center a settlement payment that represents the difference in rates for services provided during the interim period. If the final base rate is less than the interim rates, BMS will compute and recoup from the center/clinic any overpayment resulting from the differences in rates for the services provided in the interim period.

3. SERVICES CONSIDERED AN ENCOUNTER

The following services qualify as clinic/center encounters:

a. Covered Core Services are those services provided by:
   1. Physician services specified in 42 CFR 405.2412;
   2. Nurse practitioner or physician assistant services specified in 42 CFR 405.2414;
   3. Clinical psychologist and clinical social worker services specified in 42 CFR 405.2450
   4. Visiting nurse services specified in 42 CFR 405.2416;
   5. Nurse-midwife services specified in 42 CFR 405.2401;
   6. Preventive primary services specified in 42 CFR 405.2448;
   7. Diabetes Self-Management Therapy specified in 42 CFR 405.2463;

8. Medical Nutrition Therapy specified in 42 CFR 405.2463; and
9. Advanced Practice Registered Nurse specified in 42 CFR 440.166

b. Covered Non-Core Services
All other ambulatory services, except for radiology, pharmacy, and laboratory services, as defined and furnished in accordance with the approved State Plan.

c. Services and supplies incidental to the professional services of encounter-level practitioners are included in the encounter rate paid for the professional services when the services and supplies are:

1. Furnished as an incidental, although integral, part of the practitioner's professional services;
2. Of a type commonly furnished either without charge or included in the center/clinic bill;
3. Of a type commonly furnished in a provider's office (e.g. tongue depressors, bandages, etc.);
4. Provided by center employees under the direct, personal supervision of encounter-level practitioners; and
5. Furnished by a member of the center's staff who is an employee of the center (e.g. nurse, therapist, technician or other aide).

d. A billable encounter is defined as a face-to-face visit between an eligible practitioner and a patient where the practitioner is exercising independent professional judgment consistent within the scope of their license.

e. Only one medical encounter, one behavioral health and one dental encounter per day per member may be billed except in cases in which the member suffers illness or injury requiring additional diagnosis or treatment.

4. CHANGE IN SCOPE OF SERVICES

a. A change in scope of services is defined as a change in the type, intensity, duration and/or amount of services (a "qualifying event") provided by the clinic/center. A change in scope of service applies only to Medicaid covered services.

A change in scope of service may be recognized if any of the following qualifying events occur:

1. Addition of a new clinic/center service(s) that is not present in the existing PPS rate;

2. Deletion of an existing service;
3. A change in service resulting from opening or relocating a center or clinic site;
4. A change in service resulting from federal or state regulatory requirements; **OR**
5. A change in sites or scope of services approved by the Health Resource and Services Administration ("HRSA").

b. All of the following criteria must be met to qualify for a change in scope adjustment:

1. The qualifying event must have been implemented continuously for six (6) consecutive months;
2. The cost attributable to the qualifying event, on a cost per visit basis, must account for an increase or decrease to the existing PPS rate of five-percent (5%) or greater. To determine whether the threshold is met, the cost per visit of the year immediately preceding the cost reporting year in which the qualified even occurs will be compared to the PPS rate in effect for the year in which the change in scope has been implemented for six (6) consecutive months; and
3. The cost related to the qualifying event shall comply with Medicare reasonable cost principles. Reasonable costs, as used in rate setting is defined as those costs that are allowable under Medicaid cost principles, as required in 45 CFR 92.22(b) and the applicable OMB circular, with no productivity screens or per visit payment limit applied to the rate. Reasonable costs do not include unallowable costs.

c. Each clinic/center will be responsible for notifying BMS of a qualifying event by the last day of the third month after the qualifying event has been implemented for six (6) consecutive months or a maximum of nine (9) months from the date of the qualifying event implementation.

d. Each clinic/center will be responsible for providing sufficient documentation, including any and all documentation requested by BMS, to support the review and request for a determination of change in scope.

e. Providing that all notification timeframes in 4(c) and (d) above are met and a qualifying event is established, the adjusted PPS rate will be retroactively applied back to the date the change in scope was implemented.

f. Failure to meet all the notification timeframes in 4(c) and (d) above shall result in the effective date of the approved rate to be the first day following

g. the fiscal year end that the clinic/center submitted the documentation for the change in scope.

h. A clinic/center may apply only once during any fiscal year for an adjustment due to a change in scope of service.

5. ADMINISTRATION OF MANAGED CARE CONTRACTS

Where a center/clinic furnishes services pursuant to a contract with a managed care organization, BMS will make supplemental payments to the extent required by Section 1902(bb)(5) of the Act.

(iii) Reimbursement to those providers dually licensed as Behavioral Health and Residential Child Care Facilities will be prospective based on allowable provider specific cost for treatment within each peer group level. Reimbursement will be capped for individual providers within each peer group level based on allowable provider specific cost.

Allowable Provider Specific Cost

Reimbursement for Behavioral Health Residential Child Care Facilities is limited to those costs required to deliver allowable medically necessary behavioral health treatment services by an efficient and economically operated provider. Costs determined to be reasonable and allowable by the Department will be reimbursed up to the level of the peer group ceiling derived from the weighted average cost of providers by peer group. These costs specifically exclude costs for room, board and the minimum supervision required by Social Services licensing regulations.

Peer Group Ceiling

The peer group ceiling will be derived from the weighted average per patient day treatment costs of all providers, at an assigned occupancy of 90% in the peer group. Patient day is defined as eight (8) continuous hours in residence in the facility in a twenty-four hour period during which the patient receives medical services.

Efficiency Allowance

When a provider's actual allowable per diem costs are below the peer group ceiling an incentive of 50% of the difference between the provider's allowable cost and the peer group ceiling within each level of care (if lower than the peer group ceiling) will be paid, up to a maximum of four dollars ($4) per resident day.

Inflation Factor

A factor will be assigned to cost as a projection of inflation for subsequent rate setting cycles. Changes in industry wage rate and supply costs compared with CPI are observed and the lesser amount of charge is expressed as a percentage and applied to the allowable reimbursable costs for the six-month reporting period.

This inflation factor represents the maximum rate of inflation recognized by the Department for the rate period.

Cost Reporting Periods

Cost reports must be filed with the State agency. Cost reports must be postmarked within sixty (60) days following the end of each six month cost reporting period: January 1-June 30 and July 1-December 31. Rates will be calculated and effective for six month periods starting three months after their reporting period. Rates will be frozen at the current level (January to June 2001) and will remain at that level for no longer than two rate periods.

3. Other Laboratory and X-ray Services

Laboratory Services:

Payment shall be the lesser of 90% of the Medicare established fee or the provider's usual and customary fee. All fees are published on the web at: www.wvdhhr.org then medical services.

Reimbursement shall be the same for governmental and private providers.

X-Ray Services:

The following will apply to the technical component for radiology services:

An upper limit is established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge for the service to the general public. The agency's fees were set as of January 1, 2008 and are effective for services on or after that date. All fees are published on the web at: www. wvdhhr.org then medical services. Except as otherwise noted in the plan, state developed fees are the same for both governmental and private providers.